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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/19/2012 | |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 | | | |
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| K0000 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/19/12</p> <p>Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Community Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms except</p> | | | K0000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2012

FORM APPROVED

OMB NO. 0938-0391

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| | <p>resident rooms 133 through 141 and 233 through 237. The facility has a capacity of 115 and had a census of 107 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | | | | |

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| K0015 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in the employee breakroom and the Housekeeping Supervisor's office. This deficient practice could affect any resident, staff or visitor in the vicinity of the employee breakroom or the Housekeeping Supervisor's office.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, the common wall separating the employee breakroom from the Housekeeping Supervisor's office had wood paneling installed over the entire wall from floor to ceiling in the employee breakroom and had vinyl coated cork board installed on the entire wall from</p> | | K0015 | <p>It is the practice of this provider to ensure that all interior finish for rooms and spaces not used for corridors or exit ways, including exposed interior surfaces of building such as fixed or movable walls. Partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The entire wall separating the employee break room and the Housekeeping Supervisor's office has been treated with flame retardant material from the floor to the ceiling. There is documentation available for review for flame rating. How will you identify other residents having the potential to be affected by the same deficient practice ? All residents who reside in the facility have the potential to be affected</p> | | 07/19/2012 | |

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| | <p>floor to ceiling in the Housekeeping Supervisor's office. Based on interview at the time of the observations, the Maintenance Supervisor stated neither wall had been treated with flame retardant material and acknowledged no flame spread rating documentation was available for review for the wood paneling or the vinyl coated cork board.</p> <p>3.1-19(b)</p> | | | <p>by this alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director has been in-serviced and educated on assuring that all interior finish for rooms and spaces not used for corridors or exit ways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. Maintenance Director or designee will do an audit of all interior finishes ensuring they have documentation of flame rating. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI committee will review the results of the audit conducted by the Maintenance Director/designee for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance. Date of Compliance 7/19/12</p> | | | |

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| K0029 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 14 doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch each door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the two kitchen entry doors from the Main Dining Room on the first floor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, the two kitchen entry doors from the Main Dining Room on the first floor are each not equipped with a positive latching device to latch the door into the door frame. Based on interview at the time of the observations, the</p> | | K0029 | <p>It is the practice of this provider to ensure that One hour fire rated construction or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? All doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch each door into the door frame. How will you identify other</p> | | 07/19/2012 | |

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| | <p>Maintenance Supervisor acknowledged the two kitchen entry doors from the Main Dining Room on the first floor were not equipped with a positive latching device to latch each door into the door frame.</p> <p>3.1-19(b)</p> | | | | <p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director has been in-serviced on assuring that all doors protecting hazardous areas have a positive latching device to latch each door into the door frame. Maintenance Director/Designee will make rounds weekly x 4 and then monthly thereafter to ensure all doors latch to the door frame. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI committee will review the results to make sure all doors protecting hazardous areas latch to door frames for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance. Date of Compliance 7/19/12</p> | | |

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| K0038 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a</p> | | K0038 | <p>It is the practice of this provider to ensure exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The front entrance exit door will release its lock within 15 seconds of application of force. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director was in-serviced on assuring all doors equipped with delayed egress locks are readily accessible for residents, staff and visitors. Maintenance staff will test all doors equipped with delayed egress locks weekly x 4 and monthly thereafter to assure locks will release within 15 seconds of applying force. How will the corrective action(s) will be monitored to ensure the</p> | | 07/19/2012 | |

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| | <p>delay not exceeding 30 seconds shall be permitted. This deficient practice could affect any resident, staff or visitor wanting to exit the facility using the Front Lobby exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, the Front Lobby exit door is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door release device, but the exit door did not release within 15 seconds when the door was pushed with the application of force five separate times. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Front Lobby exit door is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door release device, but the exit door did not release within 15 seconds when the door was pushed with the application of force five separate times.</p> <p>3.1-19(b)</p> | | | | <p>deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI committee will review the results of the egress locks conducted by the Director of Maintenance/Designee for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance. Date of Compliance 7/19/12</p> | | |

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| K0046 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>Based on observations, record review and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 11 of 11 battery operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights-Test Log" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/20/12, documentation of functional testing conducted at 30 day intervals for the eleven battery operated lights was not available for review for the six month</p> | | K0046 | <p>It is the practice of this provider to ensure that emergency lighting of atleast 1 ½ hour duration is provided in accordance with 7.9. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? All emergency lighting equipment and batteries have been tested to ensure that emergency lighting will be fully operational for not less than a 1½ hour duration. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?Maintenance Director/Designee was in-serviced by the Executive Director on assuring that there is periodic testing of emergency lighting equipment on 30 day intervals and an annual test will be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. How the</p> | | 07/19/2012 | |

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| | <p>period of June 2011 through December 2011. Documentation of annual testing of each battery powered emergency lighting system for not less than 1 ½ hour duration was not available for review for the period of June 2011 through May 2012. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, there are eleven battery operated emergency lights located in the facility. Based on interview at the time of record review, the Maintenance Supervisor stated each battery operated emergency light is tested on a monthly basis but acknowledged documentation was not available for review of the thirty day interval testing for the period of June 2011 through December 2011, and annual testing for each of the eleven battery operated emergency lights in the facility for the period of June 2011 through May 2012.</p> <p>3.1-19(b)</p> | | | | <p>corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI Committee led by the Executive Director will review the results of emergency lighting equipment and battery powered emergency lighting system tests to ensure compliance. Date of Compliance 7/19/12</p> | | |

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| K0048 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitor in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Disaster Action Plan: Fire Prevention" and "Emergency Action Program: Fire Extinguishers" documentation during record review with the Maintenance Supervisor from 9:25 a.m. to 11:25 a.m. on 06/19/12, the facility's written fire safety plan did not</p> | | | K0048 | <p>It is the practice of this provider to ensure that there is a written plan for the protection of all patients and for their evacuation in the event of an emergency. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The fire safety plan addresses the use of ABC type fire extinguishers and the K-Class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The Emergency Action Plan includes a policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? The Maintenance</p> | | 07/19/2012 |

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| | <p>address the use of ABC type fire extinguishers and the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher.</p> <p>3.1-19(b)</p> | | | <p>Director/Designee will check all disaster manual locations 1 x monthly to ensure all are in the appropriate locations with appropriate policies in place. Instructions for K-class extinguishers: In case of an appliance fire, actuate the appliance hood fire suppression system prior to using the K-Class extinguisher. 1. Safety practices for Class A combustibles include: A. Disposing of waste daily. B. Keeping work and/or living areas clean and orderly, free of debris and floor storage. C. Keeping combustibles away from accidental ignition sources (air conditioning/heating units, electrical cords, over bed lights, etc.) D. Planning the use of combustibles in any operation so that excessive amounts need not be stored. E. Removal of plastic covers on lampshades before putting to use. F. Storing of matches and lighters/fluids in metal containers or drawers in small quantities. 2. Class B combustibles are flammable liquids, gases and aerosols. Common Class B combustibles include: oils, greases, gasoline solvents, oil-based paints and lacquers, oxygen, bottled gas and all items packaged in aerosol spray cans. Safety practices for Class B combustibles include: A. Using only approved containers, equipment and apparatus for the storage, handling and use of Class B Combustibles (i.e. paint</p> | | | |

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| | | | | <p>thinner or gasoline will not be stored in unauthorized plastic containers).B. Assuring all respective containers are conspicuously and accurately labeled as to their contents. Material Safety Data information included in labeling as required.C. Liquid from tanks, drums or barrels will be dispensed by use of approved pumps or self-closing valves or faucets.D. Class B combustibles will be stored only in the areas where vapors cannot reach any source of ignition. Highly flammable combustibles such as solvents and gasoline products will not be stored in buildings that are licensed or comprehensive nursing care or other buildings used as residence. The Maintenance Department is responsible for assuring all items are appropriately stored and labeled.E. Class B combustibles will not be used for any cleaning procedure inside a building except in a closed machine approved for that purpose.F. Class B combustibles will not be used in or near exits, stairways or other normal egress locations.G. The use and storage of all Class B combustibles will be reported to the Maintenance Director and approved for use. H. Gasoline powered vehicles will be stored outdoors in approved garage areas.I. All oxygen tanks must be turned OFF when not in use by the resident. 3. Class C</p> | | | |

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| | | | | <p>combustibles include all electrical equipment and sources of electrical current (i.e. appliances, machinery, electrical outlets, cords, etc.). Safety Practices for Class C Combustibles include: A. Frequent inspection of equipment plugs and wires to ensure integrity. Avoid pulling on wire to disconnect plug from wall outlet.B. Electrical equipment will be placed and used at a safe distance from Class A and B combustibles, with clearances in conformance with manufacturer's instructions.C. Fused power strip cords approved by the Maintenance Director may be used for non-medical equipment. Location for use as well as type of cord must be approved.D. Electrical receptacles and circuits will not be overloaded by use of outlet adapters.E. The Maintenance Department will be promptly notified of any defective wall outlets, outlet plate covers or frayed wiring.F. All appliances, including but not limited to televisions, radios, electric razors, microwaves, fans or heaters, etc. must be presented to the Maintenance Director for inspection upon arrival at the facility for residents or facility use.G. <u>The use of extension cords in lieu of permanent wiring is prohibited.</u> Space heaters may not be used in any area of the facility.How the corrective action(s) will be monitored to ensure the deficient practice</p> | | | |

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| | | | | <p>will not recur, i.e. what quality assurance program will be put into place?The CQI Committee led by the Executive Director will review the results of Disaster Plans to ensure compliance. Date of Compliance 7/19/12</p> | | | |

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| K0050 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the second and third shift for 2 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/20/12, there is no documentation available for review of a fire drill conducted on the second shift for the third quarter of 2011 and for the third shift for the fourth quarter of 2011. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no documentation available for review of a fire drill being conducted on the second shift for the third quarter of</p> | | K0050 | <p>It is the practice of this provider to ensure fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? An in-service was conducted with the Maintenance Director/Designee to ensure fire drill performed are unexpected and are at least conducted at least conducted quarterly on each shift. An in-service was conducted with the</p> | | 07/19/2012 | |

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| | <p>2011 and for the third shift for the fourth quarter of 2011.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document the transmission of the fire alarm signal for 1 of 4 fire drills conducted prior to 9:00 p.m. on the first shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation during record review with the Maintenance Supervisor from 9:25 a.m. to 11:25 a.m. on 06/19/12, documentation for the first shift fire drill conducted on 01/17/12 at 9:30 a.m. did not include the transmission of the fire alarm signal. Written documentation of the fire drill stated "No" in response to "Was it verified that the monitoring service received the alarm?" Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of the first shift fire drill conducted on 01/17/12 at 9:30 a.m. did</p> | | | | <p>Maintenance Director/Designee by the Executive Director to ensure all fire drills conducted will include the transmission of the fire alarm signal and simulation of emergency fire conditions. How will you identify other residents having the potential to be affected by the same deficient practice? All residents who receive laboratory services who reside in the facility have the potential to be effected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? A fire drill schedule was developed to ensure fire drills conducted are at unexpected times and under varying conditions and include the transmission of the fire alarm signal and simulation of emergency fire conditions. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI Committee lead by the Executive Director will review the results of the fire drill for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance. Date of Compliance 7/19/12</p> | | |

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| | <p>not include transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure all documented fire drills included the transmission of a fire alarm signal to the monitoring company for 1 of 4 quarters for the third shift. NFPA at 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation during record review with the Maintenance Supervisor from 9:25 a.m. to 11:25 a.m. on 06/19/12, documentation for the third shift fire drill conducted on 06/11/11 at 2:30 a.m. did not include the transmission of the fire alarm signal. The 06/11/11 documented fire drill report did not include information regarding the transmission of the fire alarm signal to the monitoring company during the fire drill, the day before, or the day after the third shift fire drill. Based on interview at the time of record review, the Maintenance</p> | | | | | | |

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| | <p>Supervisor stated fire drills conducted on the third shift do not include transmission of the fire alarm system signal during the fire drill or the day before or after the third shift fire drill and acknowledged transmission of the fire alarm system signal is not documented on the 06/11/11 "Monthly Fire Drill Report".</p> <p>3-1.19(b)</p> | | | | | | |

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| K0064 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observations and interview, the facility failed to inspect 7 of 16 portable fire extinguishers for 4 of 12 months. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and at least the initials of the person performing the inspection being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure a fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with, and there is no obvious or physical damage or condition to prevent its operation. This deficient practice affects all residents, staff and visitor in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, the most recent documented monthly inspection on inspection tags affixed to the following portable fire</p> | | K0064 | <p>It is the practice of this provider to ensure that all portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? All portable fire extinguishers have been inspected. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director/Designee will be in-serviced by Executive Director to ensure that all portable fire extinguishers are inspected at least 1 x monthly with the date of the inspection and atleast the initials of the person performing the inspection recorded. All portable fire extinguishers within facility will be inspected 1 x monthly with the date of inspection and atleast the initials</p> | | 07/19/2012 | |

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| | <p>extinguishers was:</p> <p>a. January 2012 for the fire extinguisher located on second floor by the MDS Coordinator's Office.</p> <p>b. April 2012 for the fire extinguishers located on the first floor by Room 123, Room 130 and Room 140.</p> <p>c. March 2012 for the fire extinguishers located on the first floor by the Activities Room, Housekeeping Office and by Room 116.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor stated no other documentation of monthly inspections was available for review and acknowledged portable fire extinguishers in the aforementioned locations did not have documented monthly inspections for the period of February 2012 through May 2012.</p> <p>3.1-19(b)</p> | | | <p>of the person performing the inspection being recorded. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put intoThe CQI Committee led by the Executive Director will review the results of the fire extinguisher inspection results. If compliance is not achieved, an action plan will be developed to ensure compliance. Date of Compliance 7/19/12</p> | | | |

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| K0069 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>1. Based on record review, observation and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:25 a.m. to 11:25 a.m. on 06/19/12,</p> | | | K0069 | <p>It is the practice of this provider to ensure that the cooking facility is protected in accordance with 9.2.3.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>The kitchen exhaust system was cleaned and the hood extinguishing system was inspected and serviced.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>Maintenance Director/Designee will be in-serviced by Executive Director to ensure that the kitchen exhaust system is cleaned semi-annually.</p> <p>Maintenance Director/Designee will be in-serviced by Executive director to ensure that the kitchen extinguishing system is inspected and serviced 1 x every 6 months.</p> <p>How the corrective action(s) will be monitored to ensure the</p> | | 07/19/2012 |

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| | <p>documentation of semiannual kitchen range hood cleaning was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, the Fire Safety Company affixed a sticker to the kitchen range hood stating the range hood system was last cleaned in May 2012. Documentation of semiannual cleaning prior to May 2012 was not observed affixed to the range hood. Based on interview at the time of record review and observation, the Maintenance Supervisor acknowledged documentation of semiannual kitchen exhaust system cleaning prior to May 2012 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen.</p> <p>Findings include:</p> | | | <p>deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>The CQI Committee led by the Executive Director will review the kitchen exhaust system after it is cleaned. If compliance is not achieved, an action plan will be developed to ensure compliance.</p> <p>The CQI Committee led by the Executive Director will review the results of the hood extinguishing inspection. If compliance is not achieved, an action plan will be developed to ensure compliance.</p> <p>Date of Compliance 7/19/12</p> | | | |

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| | <p>Based on record review with the Maintenance Supervisor from 9:25 a.m. to 11:25 a.m. on 06/19/12, documentation of semiannual kitchen hood extinguishing system service records was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged semiannual kitchen hood extinguishing system service documentation was not available for review.</p> <p>3.1-19(b)</p> | | | | | | |

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| NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 | | | |
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| K0076 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 oxygen storage locations of greater than 3000 cubic feet was enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room located inside the Bathing Room on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, there is an oxygen storage room located inside the Bathing Room on the first floor. The entry door to the oxygen storage room had no fire rating label affixed to the door and there was a one foot by six inch louver opening near the bottom of the door. Four liquid</p> | | K0076 | <p>It is the practice of this provider to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. a) Oxygen storage locations of greater than 3,000 cu. Ft. are enclosed by one –hour separations b) Locations for supply systems of greater than 3,000 cu.ft are vented to the outside. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The door to the oxygen storage room on the first was replaced with a door that provided one hour fire resistive construction. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic</p> | | 07/19/2012 | |

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| | <p>oxygen tanks were observed in the room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the entry door to the oxygen storage room did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p> | | | <p>changes will you make to ensure that the deficient practice does not recur? Maintenance Director/Designee will be in-serviced by Executive Director to ensure that all oxygen storage locations greater than 3,000 cu.ft. are enclosed with a separated with a one hour fire resistive construction. Maintenance Director/Designee will do monthly rounds to ensure that oxygen storage areas are appropriately separated from other portions of facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI Committee led by the Executive Director will review results for doors for all oxygen storage locations. If compliance is not achieved, an action plan will be developed. Date of Compliance 7/19/12</p> | | | |

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| K0143 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room located inside the Bathing Room on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m.</p> | | K0143 | <p>It is the practice of this provider to ensure that transferring oxygen is: a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; b) In an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and c) In an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The door to</p> | | 07/19/2012 | |

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| | <p>on 06/19/12, there is an oxygen storage and transfilling room located inside the Bathing Room on the first floor. The entry door to the oxygen storage and transfilling room had no fire rating label affixed to the door and there was a one foot by six inch louver opening near the bottom of the door. Four liquid oxygen tanks were observed in the room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the entry door to the oxygen storage and transfilling room did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p> | | | <p>the oxygen storage room on the first floor is now separated with a fire barrier of 1 hour fire resistive construction from any portion of the facility wherein residents are housed, examined, or treated. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director/Designee will be in-serviced by Executive Director to ensure that all oxygen storage areas where transferring of oxygen takes place is separated from portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire construction. Maintenance Director/Designee will do monthly rounds to ensure that oxygen storage areas are appropriately separated from other portions of facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI Committee led by the Executive Director will review oxygen storage location separation. If compliance is not</p> | | | |

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| | | | | | achieved, an action plan will be developed. Date of Compliance 7/19/12 | | |

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| K0144 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 4 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency</p> | | K0144 | <p>It is the practice of this provider to ensure that the generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? The emergency generator starting battery has been inspected and will continue to be inspected. A load test has been conducted on the emergency generator. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director/Designee will be in-serviced by Executive Director to a monthly load test is done on the emergency generator 1 x monthly. Maintenance Director/Designee will be in-serviced by Executive Director to ensure the emergency generator starting battery is</p> | | 07/19/2012 | |

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| | <p>Generator-Weekly Inspection Checklist" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/19/12, weekly emergency generator starting battery inspection records for December 2011 were not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged weekly emergency generator starting battery inspection records for December 2011 were not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for 3 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes,</p> | | | | <p>checked 1 x weekly. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI Committee led by the Executive Director will review the results of the emergency generator tests. If compliance is not achieved, an action plan will be developed to ensure compliance. Date of Compliance 7/19/12</p> | | |

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| | <p>using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/19/12, monthly load test documentation was not available for review for the period of March 2012 through May 2012. Based on interview at the time of record review, the Maintenance Supervisor acknowledged monthly load test documentation was not available for review for the period of March 2012 through May 2012.</p> | | | | | | |

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| | 3.1-19(b) | | | | | | |

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| K0154 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 107 of 107 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch Policy</p> | | | K0154 | <p>It is the practice of this provider to ensure that where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? A policy has been written containing procedures that are to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not</p> | | 07/19/2012 |

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| | <p>and Procedure" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/19/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would only be notified in the event of a fire. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health, alarm company, local fire department, and building owner/manager in the event the automatic sprinkler system is out of service for four hours or more in a 24 hour period.</p> <p>3.1-19(b)</p> | | | <p>recur? The Maintenance Director/Designee will check all disaster manual locations 1 x monthly to ensure all are in the appropriate locations with appropriate policies in place. Fire Watch Policy and Procedure Policy: It is the policy of this Provider to implement a firewatch in case of emergency situations in which the fire suppression system and/or the fire alarm system are out of service for a period of time longer than 4 hours in a 24-hour period. It is the policy of this Provider to implement a firewatch at other times as determined by the Executive Director, Director of Nursing or Maintenance Director as needed. With the implementation of any Firewatch for any justifiable reason, the Executive Director or designee will notify all necessary entities to include a. State Department of Health 317-233-7442 b. Insurance Company (Connor Insurance 317-808-7711 c. Owners (via Director of Operations/C.O.O.) 317-523-4786 d. Security Monitoring Company (Central Security) 317-543-1300 e. Local Fire Department 911 f. Any other necessary entities deemed necessary or required by law.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The CQI Committee led by the</p> | | | |

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| | | | | Executive Director will review the results of Disaster Plans to ensure compliance. Date of Compliance 7/19/12 | | | |

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| K0155 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 107 of 107 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch Policy and Procedure" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/19/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the authority having jurisdiction, the Indiana State Department of Health, would only be notified in the event of a fire. Based on interview at the time of record review, the Maintenance</p> | | K0155 | <p>It is the practice of this provider to ensure that where a required fire alarm system is out of service for more than four hours in a 24 hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p> <p>What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?</p> <p>A policy has been written containing procedures that are to be followed in the event the fire alarm system is out of service for more than 4 hours in a 24 hour period.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents who reside in the facility have the potential to be affected by this alleged deficient practice.</p> <p>What measures will be put into</p> | | 07/19/2012 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/19/2012 | |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218 | | | |
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| | <p>Supervisor acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health would occur in the event the fire alarm system is out of service for four hours or more in a 24 hour period.</p> <p>3.1-19(b))</p> | | | <p>place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <p>The Maintenance Director/Designee will check all disaster manual locations 1 x monthly to ensure all are in the appropriate locations with appropriate policies in place.</p> <p>Fire Watch Policy and Procedure</p> <p><u>Policy:</u> It is the policy of this Provider to implement a firewatch in case of emergency situations in which the fire suppression system and/or the fire alarm system are out of service for a period of time longer than 4 hours in a 24-hour period.</p> <p>It is the policy of this Provider to implement a firewatch at other times as determined by the Executive Director, Director of Nursing or Maintenance Director as needed.</p> <p>With the implementation of any Firewatch for any justifiable reason, the Executive Director or designee will notify all necessary entities to include</p> <ul style="list-style-type: none"> a. State Department of Health 317-233-7442 b. Insurance Company (Connor Insurance) 317-808-7711 c. Owners (via Director of Operations/C.O.O.) 317-523-4786 d. Security Monitoring Company (Central Security) 317-543-1300 e. Local Fire Department 911 f. Any other necessary entities deemed necessary or required by | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| | | | | <p>law.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <p>The CQI Committee led by the Executive Director will review the results of Disaster Plans to ensure compliance.</p> <p>Date of Compliance 7/19/12</p> | | | |